HOME DELIVERED MEALS APPLICATION

DATE:_____

NAME:_____

ADDRESS:_____

PHONE:_____BIRTH DATE_____GENDER_____

PHYSICIAN NAME _____ PHONE _____

ADDRESS _____ CITY _____

PHYSICIAN'S SIGNATURE_____

REASON FOR HOME DELIVERED MEALS_____

SUGGESTED DIET:____ No restrictions _____No added sugar _____No added salt

Beverage choice (select one)____whole milk___skim milk ___2% milk ___apple ___OJ ___cranberry

MOBILITY: _____AMBULATORY _____ WHEELCHAIR _____ WALKER OR CANE

LIVING CONDITIONS: _____RESIDES W/SPOUSE _____ LIVES ALONE _____ RELATIVE

1. Is client able to travel to places outside the home?	____Yes	____No
2. Is client able to prepare meals?	____Yes	____No
3. Is the client able to do routine housework?	____Yes	____No
4. Is the client able to follow medical directions?	____Yes	____No
5. Does the client have family/friends to assist on weekends?	____Yes	____No
6. Does the client have family/friends to assist in evenings?	____Yes	____No
7. Is the client able to take care of personal finances?	____Yes	____No

♦♦♦♦♦**EMERGENCY CONTACT**♦♦♦♦♦
(Family or Friend)

NAME:__ _____ ADDRESS_____

PHONE_____ RELATION_____

APPLICATION TAKEN BY: _____ ***DATE MEALS WILL BEGIN:*** _____

Revised 6/2016

Return completed application to:
Meals on Wheels
1600 S. Withers Rd.
Liberty, MO 64068
Fax: 816-439-4377